How cancer and treatment emotionally disturb sexual intimacy and relationship?

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Cancer and its treatment can interfere with sexual function. Directly by reducing the sexual response potential and indirectly by interfering with the optimal physical conditions to get erotically involved.

Next to that, cancer can seriously interrupt the intimacy of both patient and couple.

In this process, various factors can interact.

Fear and emotional disturbance can exclude intimacy for part of the couples, but in others it can enhance emotional intimacy. Differences in coping with fear, disappointment and loss can cause separation and become another reason for reduced physical intimacy.

Especially having genital cancer can decrease the sense of female or male self.

The patient's body, originally a source of pleasure and attraction, is now harbouring the disease and can become a constant reminder of that. Being visibly damaged by the treatment, the body can seriously reduce the desire for physical intimacy, and being physically damaged the body can become unable to transmit visual, tactile or other erogenous exchange.

For the partner an important aspect of healthy partnership is the balance between giving care and recharging the own battery. But for many couples it is difficult to find a proper balance between 'togetherness'and 'separateness'. That applies also for the area of sexuality.

In spite of all the here mentioned negative consequences, we should not forget that for part of the couples the cancer diagnosis and treatment will intensify intimacy and the relationship.

Sexual mediation: a new resource for couple psychotherapy

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We have tested for six years the application of mediation in the clinical approach to the problems of the couple sexuality.

We have taken into consideration sixty couples dividing them into couples with a conflict and on the contrary couples forming an alliance in their search of a solution to their sexual problems.

We have gathered their family trees with structured interviews, and reading their trigenerational family history we have been able to highlight some important contents in their educational systems:

1)the concept of male and female and the behaviour of couples in the family of origin

2)The patterns of intimacy, corporeity and power

3)The discordances between traditional and acted roles compared with the individual expectations

We have studied some periods of the couple life cycle and we have verified that sexuality goes through a crisis when the couple take their role of official couple and of a family and when they weigh the meaning of motherhood/fatherhood and their roles in a continuative relationship.

In the intervention model of the couple sexual psychotherapy, the Sexual Mediation inserts two sessions where the conflict of gender and role is reorganized. Nowadays that conflict is leading the couple to a strong instability.

If we work on rigid positions, if we clarify the meaning of male and female, if we show all the interests at stake, if we arrive at a joined definition of the problem, if we search solutions that can be shared step by step, we will be able to find very soon a solution to that conflict

Transgender medical care: for better, or worse?

A. Godano. *Vice Presidente O.N.I.G., Torino, Italy*

Objective: Transgender people in transition experience difficulties because of scarcity of public health services, and of clinically competent professionals.

Health needs vary greatly, and professionals interested in transgender care must meet the needs of transgender people, a broad definition including transsexuals, crossdressers, bi- or multi-gendered individuals.

Transgender medical care is an holistic care and must consider biopsychological, socioeconomic and spiritual health.

Design and method: Protocols are based on specific published literature and on clinical experience of clinicians. More research is needed and when literature is inconclusive, recommendations are based on current practice. Recommendations must be considered as a step in advancing discussion among experienced pratictioners rather than as rigid guidelines, and the author encourage clinicians to work together with community members. Care must be taken in applying evidence from studies of natal females to MtFs and of natal males to FtMs: little is known about physiologic differences affecting health outcomes.

Lacking large scale studies on to the over age 65 range, transgender endocrine therapy long term health effects remain uncertain.

Results: The author, dealing with transgender people since 1983, reviews morbidity and mortality in 78 MtF and 238 FtM on therapy ranging over 2 months to 47 years, with particular regard to clotting disorders, cardiovascular diseases, hypertension, diabetes, mental illness, breast, ovarian, uterine, and prostate cancer.

Conclusions: Sensitive and respectful medical treatment clearly improve mental health and quality of life of transgender people.

The Role of Drugs in Treating Female Sexual Dysfunction

I. Goldstein. *San Diego Sexual Medicine at Alvarado Hospital, San Diego, USA*

Female sexual dysfunction is a bio-psycho-social healthcare problem in which treatment options engage multiple disciplines. A consensed management paradigm engages after

the diagnosis a step-care plan which first starts with modification of reversible causes. This includes sex therapy, medication changes, physical therapy, diet and exercise, relaxation, addressing partner issues. Should the sexual health concern continue, the next step in the process of care engages non-hormonal and hormonal pharmacologic intervention. After a full discussion of the risks and benefits of each pharmacologic agent, a clinical trial is pursued and where appropriate, follow up includes validated psychometric outcome scale measurement, psychologic interview, and appropriate lab tests as needed. Hormonal drug intervention involves androgens such as systemic DHEA and testosterone, local, intravaginal, vestibular and systemic estradiol and systemic progesterone. In addition SERMS and SARMS may be considered. Non-hormonal pharmacotherapy involves vasoactive agents, dopaminergic agonist agents, alpha 2 receptor antagonist, and local and central medications for pain management. The management of women with female sexual dysfunction can be directed in a step-care process with the rational use of multi-disciplinary therapeutic interventions.

The Role of Psychology in the Biologic Pathophysiology of Female Sexual Dysfunction

I. Goldstein. *San Diego Sexual Medicine at Alvarado Hospital, San Diego, USA*

Historically FSD has been considered to be contextual and based on interpersonal relationships and personal and psychological issues including predisposing factors that may set the stage for later sexual problems like illness or anatomical deformities and early life experiences,precipitating factors that are the immediate triggers for sexual problems such as an unwanted or traumatic sexual experiences, and maintaining factors such as relationship distress or performance anxiety. Recently, however, a primary biologic-based FSD has been shown to occur following use of oral contraceptive pills, associated with SSRI use, occurring following oncologic treatments for gynecologic malignancies such as breast, cervical, uterine or ovarian cancer, and often with tissue atrophy associated with menopause. This lecture will discuss the need for concurrent psychologic and biologic management even though the pathophysiology is primarily biologic. The model for concomitant biologic and psychologic treatment of sexual health problems is modeled after that described by Perelman in the treatment of men with premature ejaculation.

Gender Dysphoria (GD): what role for the psychiatrist?

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The psychiatrist has two objectives:

- Avoid unsatisfactory results (10% of patients): in subjects whose psychological and social conditions has worsened after the operation. Transitory and definitive regrets are expressed in respectively 10 and 2% of patients. Sex reassignment surgery improves psychological conditions for most of patients, but the rates of severe depression and suicide are significantly higher than in general population.
- Optimize a successful transformation in terms of patient's global satisfaction and psycho-social adaptation to the new gender.
- The psychiatrist's role:
- Confirm GD diagnostic,
- Establish the differential diagnosis of GD related to or associated with a psychiatric pathology,
- Detect and inform the patient about negative predictive factors that concern him/her and that should be used to discuss the benefits of a surgical conversion,
- Detect unrealistic expectations to prevent undue frustrations and disappointments that will impact the surgical team,
- Make sure that the patient fully understands the limitations and consequences of SRS,
- Propose him personalized care,
- Prepare him to the transformation during the real life experience,
- Help him to confront difficulties implied by the transformation.

The objective of psychiatric assessment is not to restrict access to SRS but to identify vulnerable patients.

The psychic predictive factors of a pre-operative evolution of post-sex change disorders must be discussed within the team.

Even if these vulnerability factors are not contra-indications to sex change, they should lead to caution in order for the surgeon to be able to assess the impact of the surgical act.

Medical and sexual comorbidities: when the integrative approach is key

A. Graziottin. *Center of Gynecology and Medical Sexology - H. San Raffaele Resnati, Milan, Italy*

Sexual functions requires the integrity of the main systems of the body: hormonal, nervous, vascular, muscular, metabolic, immunitary. When one or more of these systems are dysfunctional, comorbidity with sexual problems increases with the severity of the primary disease: this is a solid concept in male sexual dysfunctions, specifically when erectile deficit emerges as the alerting symptoms of depression, cardiovascular diseases, low testosterone, or neurological problems. This is much less evident in women, where until recently the emphasis on psychosexual and relational issues has shadowed the importance of biological factors. On the other hand, when sexuality is dysfunctional, consequences may affect the medical domain. Medical and sexual comorbidities are therefore emerging as the new frontier of diagnosis and treatment of sexual dysfunctions in both genders.

The presentation will focus on women's sexuality and medical comorbidities, a most neglects issue, with a few critical examples of how comorbidities should be diagnosed and addressed: